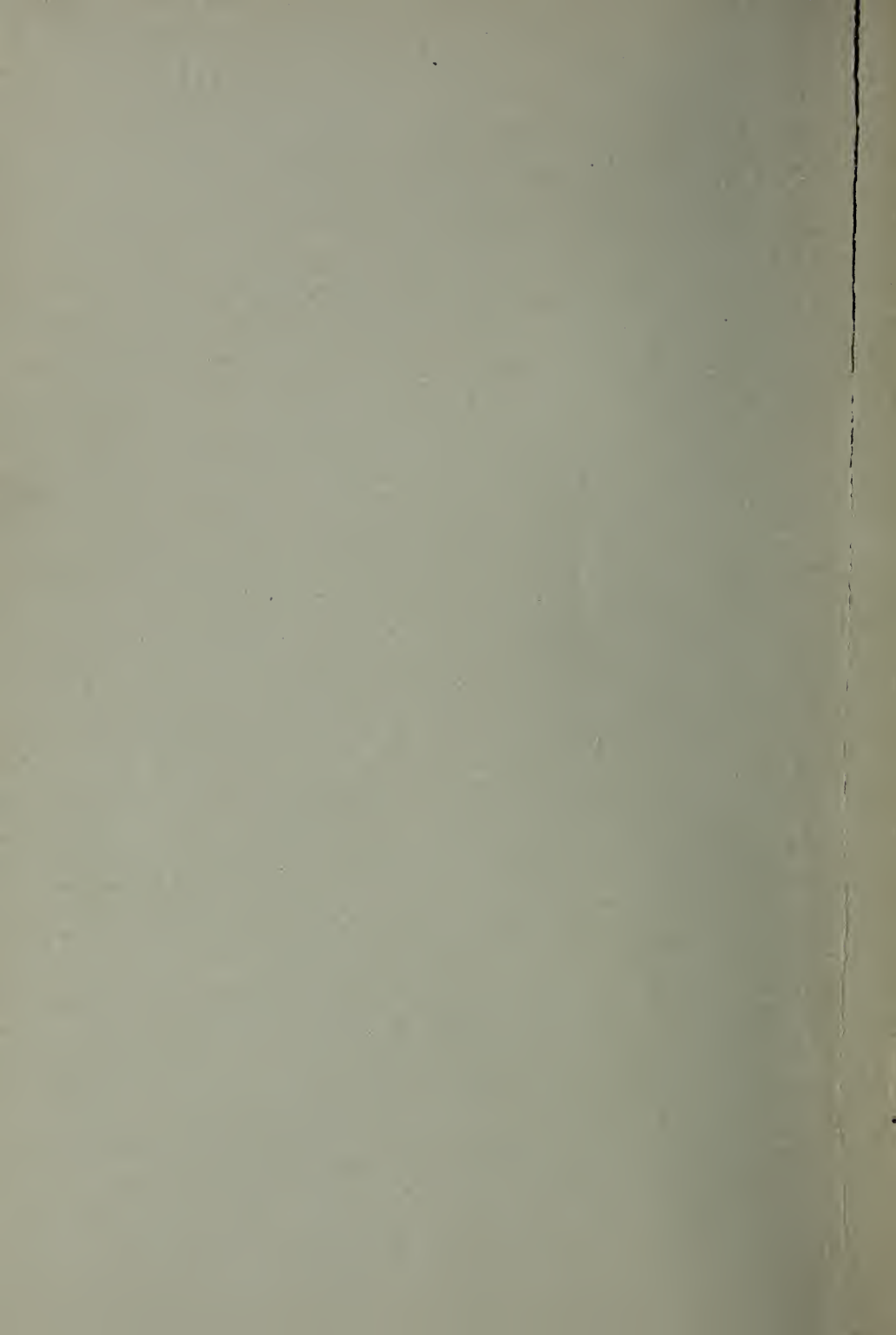


PROGRESS IN THE CLINICAL STUDY  
OF PSYCHIATRY. A STUDY OF PRINCIPLES  
IN THEIR APPLICATION TO THE CLASSIFICATION  
OF INSANITY.



PROGRESS  
IN THE  
CLINICAL STUDY  
OF  
PSYCHIATRY

BY

EDWARD COWLES, M. D.

Medical Superintendent, McLean Hospital; Professor of Mental Diseases, Dartmouth  
Medical College; Clinical Instructor in Mental Diseases,  
Harvard Medical School.

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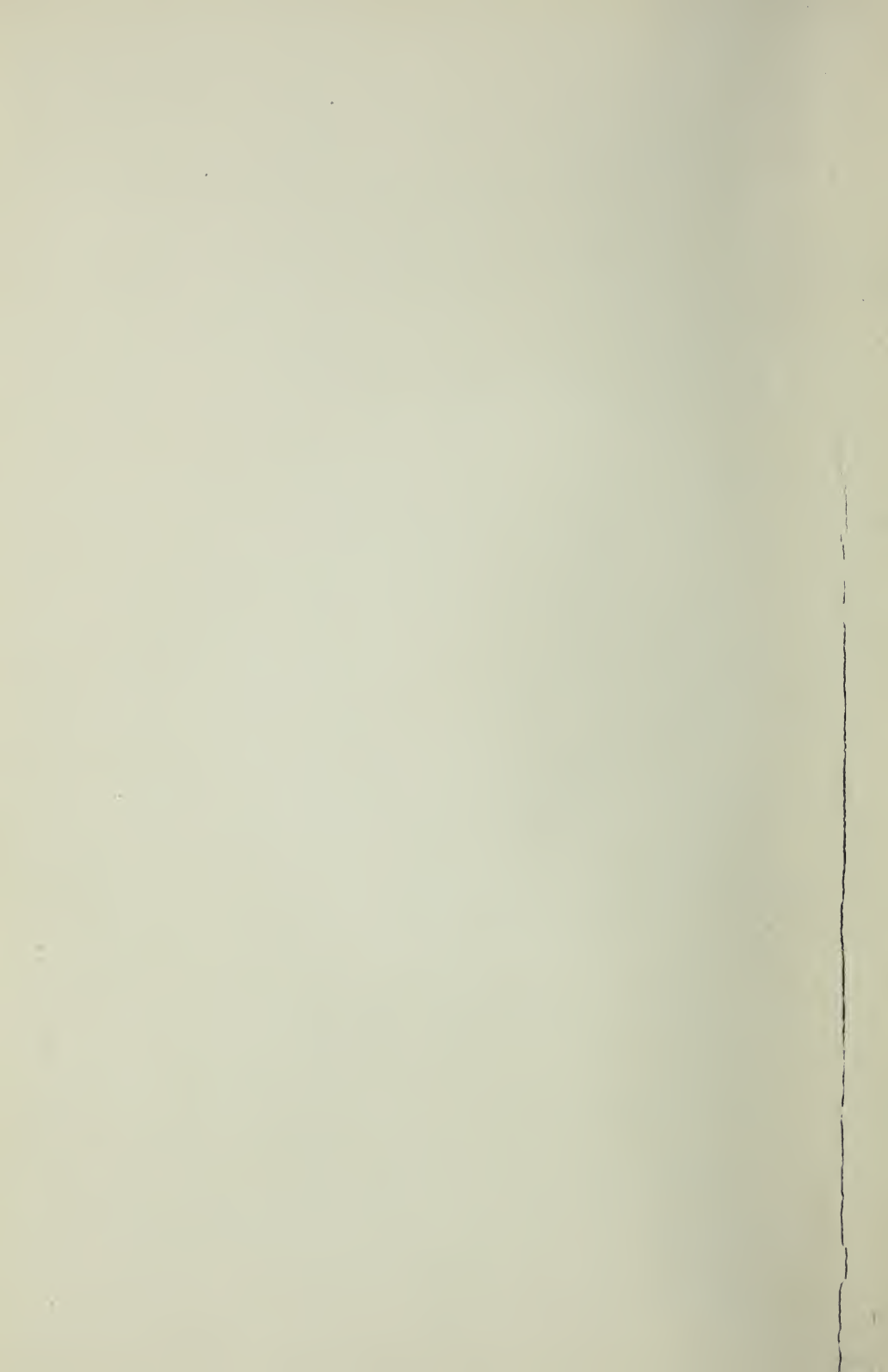
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## PROGRESS IN THE CLINICAL STUDY OF PSYCHIATRY.<sup>1</sup>

By EDWARD COWLES, M. D.,  
*McLean Hospital, Waverley, Mass.*

In speaking of the clinical work at the McLean Hospital, it is not my intention to claim that progress has been made, but rather to present some reasons for our hope of progress. Being unable, for want of time, to prepare a written paper, at the request of the Secretary, for this meeting of the Association, the privilege has been granted me of making some informal remarks upon what is now being offered us that is new in psychiatric study. Those of us who have learned our psychiatry during the last thirty years know how the earlier views that were handed down to us have prevailed and still hold us to the ideas of the acute psychoses that have so fixed the terms melancholia, mania, and dementia. I wish to speak of the effect that is produced upon these conceptions by certain newer ones which, it seems to me, should be welcomed as a great contribution to the understanding of the nature of insanity.

It has always been that some writers have tended to generalize, and to form schemes and classifications that show their goodness by their early death; others tend to specialize and to differentiate many clinical entities, most of which have lived only long enough to be named and then forgotten. There must be some reason for the vitality of that generalization under which Griesinger defined melancholia as including states of mental depression—

<sup>1</sup> This article embodies substantially the remarks made by the writer before the American Medico-Psychological Association, at New York, May 24, 1899. It is a *preliminary communication* of some of the results of special clinical studies that have been made during a number of years at the McLean Hospital, especially in the last four years. The publication of such studies will be continued, as they become sufficiently advanced, by the medical staff.

mania as states of mental exaltation—and dementia as states of mental weakness. This is a dominant conception to-day, in some form or other, as is strikingly shown in Clouston's latest edition of one of the best accepted of modern text-books. In the many attempts to get away from this generalization, the most notable one of modern times embodies the doctrine of heredity as an explaining principle. Under this the conception of paranoia has had its rise, prevalence, and decline to its truer value, within thirty-five years. The "systematized delusion" being held to be its prime characteristic, nearly all forms of insanity were included, and there were many named varieties of paranoia for which a common degenerative tendency was claimed. The term paranoia is accepted now for comparatively few cases of definitely manifested primary delusional insanity; and it is coming to be realized that a neuropathic heredity does not have the relation of an essential cause in the acute psychoses, any of which may occur without such predisposition. But out of these conceptions in regard to heredity, and concerning the form and content of the delusions, have come distinct contributions to our knowledge of mental diseases. We have been reverting to our old standbys—melancholia, mania and dementia, and their varieties—for the classification of the large majority of cases, which we have to tabulate in our hospital statistics.

One of the most interesting contributions that has been made to this subject has been the proposition that the acute psychoses constitute one disease that may be called "ordinary insanity," of which melancholia, mania, and dementia are but stages in the descent towards dementia. In English medical literature the best presentation of this conception was made by Sankey in his lectures first published thirty-three years ago, and in a revised edition in 1884.<sup>2</sup> But, as he says, "this is no new doctrine or discovery." Griesinger agrees to the unity of melancholia and

<sup>2</sup> *Op. cit.*, p. 101. "Cases of mental disease vary much in their course or progress. At one period, the subject will present phenomena totally different from the symptoms presented at a different period. I maintain, however, that the case must be considered to be of one species throughout; such is the rule in general pathology and there are no grounds for having a different system in Insanity, however long the case may last. For a case to be placed under a different name, it should differ from all other cases, as distinctly as acute rheumatism from typhoid fever."

mania as forming degrees of the same morbid state; and other writers in recent years have held this view. Yet the striking diversity in the manifestation of the emotions in the clinical pictures presented by the two phases of depression and exaltation leads to their being still described as two diseases. But while Sankey made some most instructive explanations of the mental changes from melancholia to mania he was evidently misled by his idea of "stages" in the progress of "ordinary insanity" toward dementia: they were 1, melancholia; 2, mania; 3, chronic melancholia and mania, and alternating forms; 4, dementia. The word "chronic" in his third stage refers merely to duration and implies the beginning of dementia; while this may be a stage of progress, it is not a distinct phase or aspect of the clinical picture as the depressive and excited conditions are. The unity of ordinary insanity really includes only these two phases; and there is no fourth stage, for it is comparatively rare that even a slight form of dementia occurs in the true acute psychoses; this will be explained in the course of this discussion.

The latest and most original contribution is that of Kraepelin in his studies and clinical methods which are giving us perhaps the most illuminating conceptions of insanity that we have yet received as explaining principles. For the bringing of these to us in America I wish to give here the credit due to Dr. Hoch, who went from the McLean Hospital to Heidelberg in 1894 to be a student with Kraepelin and again in 1897, and to Dr. Meyer, who also was there in 1896. During the last three years and more, in the discussions in clinical conferences at the McLean and Worcester Hospitals the Kraepelinian propositions have been worked over and, case by case, have been tested to their acceptance, modification or rejection. At the McLean Hospital we have been very conservative; and holding fast to that which seemed good in our observations in the past we have adopted new conceptions only as they have stood trial in their repeated application to concrete cases. It is one of the merits of Kraepelin, and an evidence of the soundness of his teachings, that others as well as himself, in working out the principles he lays down, must advance from one formulation of tentative conclusions to another in progress toward the truth. Nothing could be more stimulating and encouraging in our work. The funda-

mental conception is that in conformity with general pathological principles there must be an underlying pathological process for every distinct form of mental disease manifested by a definite symptom-complex. We recognize this in general paralysis, but here we take into account, as the principles of general pathology require, the cause, the pathology, the symptoms, the course, and the termination of the disease, in order to understand it in its entirety. In like manner, although yet far from demonstrating underlying pathological processes for the acute and other psychoses, we have a right to make the assumption, for each real disease; and we may, therefore, proceed to differentiate the clinical forms upon the basis of this conception, always remembering that we must include what we *can* observe of the cause, symptoms, course and outcome. We may note for example, in one group of cases, recurring attacks of simple depression, with recoveries, and with such absence of terminations in dementia as to permit us to say that these cases do not tend to it; in another group, each individual may have first a depressive attack, afterwards a recurring attack of excitement, and later other attacks, either depressive, excited, or of mixed types, but still no characteristic tendency to pronounced dementia. Again, in another group of cases, there may appear in each from the outset, certain characteristic traits that declare a tendency to dementia; although in some there may be remissions, even equivalent to recoveries, there are, nevertheless, in the symptom-complex the traits peculiar to the underlying dementing process. General paralysis is only a pronounced type of a disease presenting a well-recognized course and outcome, with sometimes superficial manifestations of depression or excitement in its course; and having possible remissions there is a certain progress toward dementia from the beginning. These conceptions bring out and emphasize the principle that when, besides the symptoms of any present attack, we take into account the course of the disease through the patient's life-time together with the final outcome of the disease, we are no longer bound down by the necessity of naming the disease melancholia at one time because there is a depression, and at another time having to call it mania because of excitement. The true criterion is the essential tendency of the disease as a whole to recovery or dementia. I regard this

as the key to the teachings of Kraepelin—this is his illuminating contribution. It follows from these conceptions and his methods of clinical study that in every case we look, from the outset, for the prognosis; we search the symptom-complex for the characteristic differential traits that point to recovery and recurrence, or to dementia with possible remissions. With such a conception of the nature and natural history, so to speak, of any given form of mental disease there is a better understanding of what may be done to promote recovery, and efforts are stimulated to overcome conditions that do not necessarily denote permanent deterioration as they superficially appear to do. It is in such considerations as these that hope of progress lies.

Kraepelin, in the fifth edition of his text-book on psychiatry, still treats the larger groups of the insanities, which we have known as melancholia, mania, etc., as chiefly belonging to the class of "constitutional psychoses" included among the "mental diseases originating from faulty endowment." But in the sixth and last edition, recently published, this ascribed relation to predisposition has disappeared and he purposely avoids schemes of classification. His lectures deal with forms of insanity as quite distinct subjects. But we, who have been grounded and brought up in the teachings of our fathers and have associated together or differentiated the forms of insanity that we most commonly see, cannot drop our working knowledge of our cases; we cannot transport ourselves to a new point of view without great apparent confusion if we lose our bearings. The student, who must still learn his psychiatry largely from our text-books as they are, must have, as well as we, some clue to what becomes of our melancholias and manias, for example, under the newer conceptions which really seem to clarify the confusion of the older teachings. It is all the more necessary, to consider the effect of Kraepelin's teachings upon our nomenclature and customary classification because in his endeavor to relieve the new position from embarrassment he tries in a number of cases to discard an old name and to find a new one to designate a newly differentiated symptom-complex.

Kraepelin (5th edition) conceives the "acute psychoses" as constituting forms of periodic insanity; these are: 1, manic forms (simple mania); 2, circular forms, depressive conditions and ex-

pansive conditions (melancholia and mania); 3, depressive forms (simple melancholia). He has preserved the word "melancholia" in the term "Melancholia" applied to climacteric cases; but finding "Involution Psychosis" a better designation we (at McLean Hospital) have seen no reason for taking the word "melancholia" away from the group of cases characterized by depression. Neither did we see in the cases we have studied any reason for making a separate group of "Manic Forms." There being a quite obvious objection to the term "Circular Forms," we regard these as "Ordinary Insanity—depressed phase and excited phase"; Kraepelin himself (6th edition) dropped the word "circular" and substituted "Manic-Depressive Insanity," which may be adopted usefully at the present stage of this discussion. Our studies, therefore, gave us the following results, comparing the older conception of the "acute psychoses" with the new one:

TABLE I.—ACUTE PSYCHOSES.

|                              |                                |
|------------------------------|--------------------------------|
| MELANCHOLIA.                 | MELANCHOLIA, Simple.           |
| States of Mental Depression. | (Periodic forms.)              |
| MANIA.                       | DEPRESSIVE-MANIACAL INSANITY.  |
| States of Mental Exaltation. | Depressed Phase (Melancholia). |
|                              | Excited Phase (Mania).         |
|                              | (Periodic and circular forms.) |
| DEMENTIA.                    | Forms above named tending to   |
| States of Mental Weakness.   | recurrence and recovery.       |

This table serves to indicate that the "melancholias" of the old order may be divided, part of them remaining as simple melancholia and another part being assigned to the "depressed phase" of the double form; the "manias" in large part also pass into the "excited phase" of the latter form. But, so far, only cases tending to recovery, and not to dementia, have been kept; there remains a part both of the old melancholias and manias that do tend to dementia. Taking away entirely from the "acute psychoses" the cases tending to dementia, this class is cleared of those difficult to assign, and which include the type of cases that may be properly called Katatonia. These katatonic cases tending to dementia thus disposed of, are the ones that often present varying states of depression, excitement, confusion, etc., in

the course of one attack, and by reason of their varying emotional states have always created embarrassment in grouping them among cases with which they have been formerly associated. On the other hand, these cases of katatonia, when grouped with other dementing cases of the well-known types of primary dementia and hebephrenia, are found to possess as characteristics certain traits common to those clinical forms; more will be said of these later in this discussion. The destination of the katatonic cases being thus indicated, it is of great interest to see the effect of their removal from the "acute psychoses." The question comes here as to what is gained by these changes. They are made in recognition of a fundamental principle. The conception of melancholia as states of depression and mania as states of exaltation constituting two diseases, has long dominated psychiatry, misled it as long, and retarded its progress. It is based upon the changes in the emotional nature—the criterion is the state of the *feelings*. In the depressive states there is something left of the normal reactions of the feelings as representing the truth of the somatic conditions, but in the exalted states the sense of well-being is fictitious and out of relation with somatic facts, and no index of underlying conditions. However this may be, instead of discriminating the "acute psychoses" upon the basis of so fluctuating a criterion as the feelings, Kraepelin points to the course and outcome of the disease as the determining facts—the criterion is as to whether or not there is a *tendency to dementia*. The "acute psychoses," the forms that are with most reason termed "symptomatic" and "functional" do not tend characteristically to dementia; recurring attacks throughout a life-time do not produce it, except sometimes, perhaps, in the slighter degrees in the later years of life, or after many attacks.

One other consideration remains to be mentioned here in connection with the "acute psychoses"; it is with regard to the place of what we have known as "confusional insanity." Kraepelin (5th edition) describes certain forms of mental disorder which he calls "exhaustion psychoses" as conditions that may be rapidly produced by any strongly exhausting influences, including the effects of mental shock or stress. These appear to me to belong among the cases of confusional insanity, as being in the nature of *deliria* in relation to conditions of acute exhaustion. They always

tend to recovery, and should, therefore, be classed with the "acute psychoses."

The conception of pathological processes as underlying "mental diseases," as far as we are yet warranted in differentiating the symptom-complex of each clinical form, gives us the criterion of the tendency to dementia as a basis for a simple and logical classification. Making such use of Kraepelin's designations as has been explained, and introducing "confusional insanity" in its appropriate place, the following tentative classification results. It comprehends the idiopathic forms of insanity in as broad and simple a generalization as that of Griesinger's formula, but upon a fundamentally different basis:

TABLE II.—CLASSIFICATION OF INSANITY.

|                                                                              |                                                             |                     |
|------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------|
| ACUTE PSYCHOSES.<br>(Not tending to Dementia.)                               | { MELANCHOLIA—Simple ("Periodic").                          |                     |
|                                                                              | { DEPRESSIVE—MANIACAL INSANITY<br>("Periodic," "Circular"). |                     |
|                                                                              | { Depressed Phase (Melancholia).<br>Excited Phase (Mania).  |                     |
|                                                                              | { CONFUSIONAL INSANITY (Exhaustion<br>Psychoses).           |                     |
| ESSENTIAL DEMENTIAS,<br>OR<br>DEMENTING PSYCHOSES.<br>(Tending to dementia.) | { DEMENTIA PRÆCOX.                                          | { Primary Dementia. |
|                                                                              |                                                             | { Hebephrenia.      |
|                                                                              | { GENERAL PARALYSIS.<br>Katatonia.                          |                     |
|                                                                              | { SENILE DEMENTIA.                                          |                     |
| CHRONIC PSYCHOSES.<br>(Not tending to grave<br>dementia.)                    | { INVOLUTION PSYCHOSIS.                                     |                     |
|                                                                              | { PRIMARY DELUSIONAL INSANITY<br>(Paranoia).                |                     |

It is impossible, for want of time, to discuss here the differentiation of the symptom-groups which constitute these forms of insanity. Each one would show distinctive characteristics which have been verified many times in series of well-studied cases. It should be explained, however, that "dementia præcox" is Kraepelin's latest designation for the three types which it includes. Certain characteristic traits common to these three are revealed by intimately studying the workings of the mental elements and their variations. These characteristics being recognized, it is found

that a fundamental unity exists even between clinical pictures so diverse as that of a primary dementia, apathetic and chronic from the beginning, and that of an actively developed katatonia running through a mixed manifestation of symptoms resembling those of the acute psychoses in sometimes a long and apparently hopeless illness, but yet yielding at last a remission apparently equivalent to a recovery from that attack. While it becomes necessary, and is very helpful in classification, to make a diagnosis of "dementia præcox" in quite a number of cases of which it can hardly be said that they are distinctly of the type either of primary dementia, or hebephrenia, or katatonia, still their relationship is very obvious. The character of general paralysis and senile dementia as manifestations of surely degenerating disease-processes, gives them a kinship with the usually more slowly progressive dementias. Involution psychosis (climacteric) and paranoia are forms that tend to run long courses, chronic from the beginning; and not tending to grave dementia they may, for the present, be called the "Chronic Psychoses." With regard to these Kraepelin would place together "Melancholia" and Senile Dementia as "Devolution Psychoses," but the present tentative grouping does not conflict with that suggestive idea.

The progress that has been made through the clinical studies which have yielded the results so far presented here may now be traced another step. I have already indicated that in studying Kraepelin's proposition (5th edition) to separate the "manic forms" and "depressive forms" as distinct from his "circular forms," it was found, at McLean Hospital, that the history of the cases did not warrant such separation for the "manic forms." Kraepelin (6th edition) now not only omits these, but he leaves out, as not sufficiently differentiated, the simple "depressive forms" also, which we have retained as a convenient division; he retains, therefore, for what we have called so far the "acute psychoses," only those under the designation "Manic-Depressive Insanity" with its two phases. While there is reason, in my opinion, for contending that the depressive state comes first, in respect to the degree of the disorder, and in the evolution of the disease, thus making preferable the term "Depressive-Maniacal Insanity," we should probably agree with Kraepelin in this his latest view, excepting a question as to a different designation of this

double form. This is a most interesting conclusion, for we have only to prefer the phrase "Ordinary Insanity," unsatisfactory as it is, to his of "Manic-Depressive Insanity," and we are brought around again to a more familiar terminology, viz.: "Ordinary Insanity," including two phases; 1, depressed phase, melancholia, and 2, excited phase, mania. This leaves us the easily-used characterizations of the differences in the contrasting emotional states, which still indicate sufficiently the accompanying symptom-complex in each phase respectively.

Again, the question arises "What have we gained?" The gain is one of immense importance; it is a radical change of the point of view. We see now that melancholia and mania are but phases manifesting different "degrees of the same morbid state"; we see that these together are the expressions of a probable pathological process which has its course sometimes extending throughout the life-time of the patient, and that it always tends to a termination in recovery with sufficient certainty to make it characteristic. At the new point of view we adopt the criterion of dementia as the distinguishing mark of the differences of course and outcome. Then, for the next group of cases, assuming the phrase "Dementing Psychoses" to be allowable, we place first in this group the cases we have long known as tending to dementia, under the various names of primary dementia, hebephrenia, adolescent insanity, etc. We find that with them belong the cases that have always been inharmonious with the group of "acute psychoses," and which we have had to designate by special descriptive terms as varieties of melancholia or mania. The contributions of Kahlbaum and Kraepelin to the study of katatonia here find their place. The term "Dementia Præcox," thus bringing together with katatonia a number of these variable forms that represent dementing processes, unifies them as belonging to one group, through the elucidation we have gained of certain characteristic traits common to all. Not only this, but, as already mentioned, it is also significant of the value of the generalization that there are cases which, because of these traits, find here a fitting place when they could hardly be designated by any one of the special names. This is true of cases that change from one appearance to another in the unessential variations of the symptom-complex in the same or in different attacks. A gain

is obvious, also, in finding in this group a logical place for its two other members—general paralysis and senile dementia.

The foregoing table, with these explanations, represents our working formula of classification, at McLean Hospital, in studying the clinical forms of mental disease and their relations to each other. We have to say, however, with respect to the group of "Chronic Psychoses," which term is ours and not Kraepelin's, that we are not yet quite satisfied as to their relations to the other groups. In other words, "involution psychosis," (Kraepelin's "melancholia"), and primary delusional insanity are yet open to question in this regard, although the former has proved to be one of the most interesting of these studies. Still, there are several plain indications in regard to these two forms of insanity, last named. To designate in this connection a group of cases as "chronic" introduces an inconsistent criterion; as they tend to dementia to a certain degree, they belong in the general class of dementing psychoses. Of these there are two special forms, or, perhaps, degrees of one form, which Kraepelin would designate as related to the process of "devolution." On the ground that the process of involution, beginning with the climacteric of middle life and terminating in senility, is a natural process of physiological decline, we may argue that psychoses occurring during that period should present some characteristic variations from the phenomena of the same underlying disease process in earlier life. At all events, the relation of climacteric insanity (involution psychosis) to senile insanity as types, or degrees, of a dementing process, is sufficiently certain; and they have a certain kinship as "Devolution Psychoses."

For like reasons to those above stated the objections to the word "chronic" apply to the use of the word "acute" in the term "acute psychoses" customarily applied to the so-called "symptomatic" and "functional" forms. The dementing psychoses are often "acute" in respect to the character and duration of the attacks. The term "Recovering Psychoses" might be used in contrast with the "Dementing" forms; but conservatively adhering by preference to the familiar designation "Symptomatic and Functional Psychoses," we may leave it for future determination whether they represent simply curable "conditions," or "underlying disease-processes."

"Progress in the clinical study of psychiatry," guided by the foregoing considerations, may be said to have brought us as "alienists of the old school" to a new point of view. In this position the effect of the new views should be made intelligible to us, as far as a scheme of classification can indicate explaining principles, by the foregoing table; this will be aided, perhaps, by some slight modifications of terminology and arrangement. The one now proposed, with its harmonizing interpretations of the nomenclature, includes substantially the conceptions of Kraepelin. While it points to the new problems in the discrimination of the clinical forms of mental disease, it does not disconcert us with changes of familiar names, although some of these must stand for more specific meanings. The following table is proposed as fairly indicating the net results, in regard to classification, of the special studies under discussion:

TABLE III.—CLASSIFICATION OF INSANITY.

|                                                                             |   |                                                                                                  |
|-----------------------------------------------------------------------------|---|--------------------------------------------------------------------------------------------------|
| "SYMPTOMATIC AND FUNCTIONAL PSYCHOSES"<br>(Not tending to dementia).        | { | ORDINARY INSANITY (Depressive—Maniacal).<br>Depressed phase—Melancholia.<br>Excited phase—Mania. |
|                                                                             |   | CONFUSIONAL INSANITY<br>(Exhaustion Psychoses).                                                  |
| ESSENTIAL DEMENTIAS,<br>or<br>DEMENTING PSYCHOSES<br>(Tending to Dementia.) | { | DEMENTIA PRÆCOX { Primary Dementia.<br>Hebephrenia.<br>Katatonia.                                |
|                                                                             |   | GENERAL PARALYSIS.                                                                               |
|                                                                             | { | PRIMARY DELUSIONAL INSANITY<br>(Paranoia).                                                       |
|                                                                             |   | DEVOLUTION PSYCHOSES. { Involution Psychosis.<br>Senile Dementia.                                |

This table includes only the idiopathic forms of insanity, leaving for classification in the usual way those from neuroses, organic brain disease, mental defect, and the toxic forms. The conception of the idiopathic psychoses and their relations to each other as embodied in this table affords us a helpful working formula to keep before us the underlying guiding principles. It may be said that there is danger in such a formula from its tempting us as students of psychiatry to force our observations of clin-

ical manifestations to fit a preconceived programme. This, surely, would be a misleading use of a scheme of classification; at the best, any such scheme should be treated as an attempt to hold up to view the fact that there are in this matter certain fundamental principles, which being applied in certain ways serve to reduce to some degree of intelligible order an array of "clinical entities," that would otherwise remain in forbidding confusion. We even have to find out these principles by testing them in these ways. Classifications fail by attempting too much; the old formula, based upon the feelings, has held because it does not go beyond certain simple, observable facts, although its inadequacy is manifest. The present suggestion has the merit of simplicity; we are led to it as the immediate effect of the application of one fundamental principle. If this is a true one, it must lead us further in the progress that has been so long hindered by erroneous conceptions.

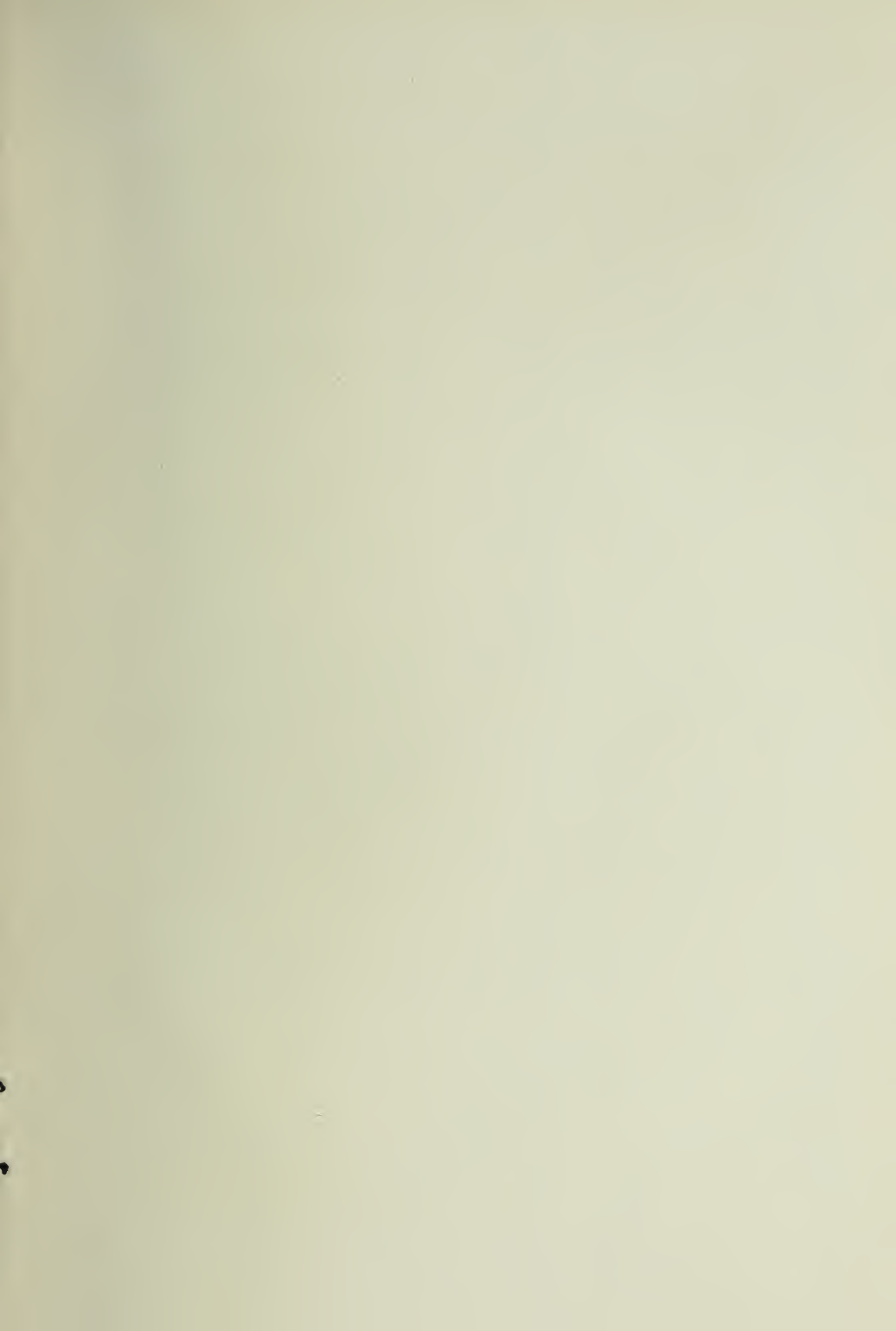
In pursuing the studies under the methods employed in the clinical work at the McLean Hospital it has been the endeavor to reach well-grounded conclusions. Those incorporated in the tabular statement of results, as far as they can be shown by the condensed expression required in a form of "classification," must continue to be subjects for study. It may prove that the conceptions and conclusions do not necessarily conflict, as they are held to do, with some of those long held by careful observers and students of psychiatry; and truth may, perhaps, be learned by studying these apparently conflicting views in an attempt to harmonize them. When it was my privilege to present to the Association, at its meeting in Newport, in 1888, a discussion of this subject,<sup>8</sup> the proposition was offered that the acute psychoses comprised "Ordinary Insanity" in three stages, melancholia, mania and dementia. It was argued that on the dual basis of nervous exhaustion, or its equivalent, and toxicity there could be traced a regular evolution of the symptom-complex of each succeeding stage from the mental symptoms of normal and pathological fatigue. These propositions are not far astray from those

<sup>8</sup> See articles on "The Mechanism of Insanity," in the *AM. JOUR. OF INSANITY*, Vols. 46, 47, 48, for a part of that discussion; also "The Shattuck Lecture, 1891," on "The Mental Symptoms of Neurasthenia," *Bost. Med. and Surg. Jour.*, Vol. 125, p. 49.

that have been quite commonly accepted in recent years. It is fair to say that this is held to be quite inconsistent with the conception of disease-processes as advocated by Kraepelin: given a disease-process it must have its own symptom-complex as a mental disease; one disease does not run into another, and "manic-depressive," or "ordinary insanity," as one pleases, has nothing to do with neurasthenia, for example.

There is some satisfaction in noting the support that has been gained for the unity of melancholia and mania as simple phases or degrees of one morbid process; and it seems reasonable to remove the cases tending to dementia from the group called "acute psychoses." All will agree that neurasthenic conditions, more or less acute, are common antecedents of these psychoses. The problem is an open one as to whether they occur independently of "exhausting" antecedents; or whether these existing, and creating a predisposing condition, the true disease-process then begins; or whether the symptom-complex must be made up of fundamentally different elements for each form of the psychoses. Again, are there certain "fatigue-symptoms" that may exist alone in conditions of simple exhaustion, but which must be taken into account as possibly appearing in all the psychoses, sometimes as an attending effect of the onset of disease, just as general paralysis sometimes has its first manifestation in an apparently neurasthenic depression, or an excitement? These are interesting studies; and there is the suggestion that the "acute psychoses," as now limited and always tending to recovery, may, in all forms, bear the relation of *deliria* to somatic conditions. An important step in progress is made when we become able to recognize definite problems such as are presented by these studies. The "fatigue question," on the one hand, touches directly the problems of nutrition and of the treatment of conditions indicated by changes in the mental symptoms; the disease-process question, on the other hand, draws attention to the study of structural changes and the possible correlation with them of the mental phenomena.

There seem to be reasons for hoping that such clinical studies are bringing substantial advancement to psychiatry; the interest excited by these methods of study, and the sense they give of an opening way for progress in which many attractive problems are appearing, bring great encouragement and stimulation to further efforts in pursuing clinical work.









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